State/Territory: MONTANA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

All ambulatory services provided to the categorically needy are provided to the medically needy.

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL MEDICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/x/Provided: / /No limitations /x/With limitations*

2.a.Outpatient hospital services.

/x/Provided: / /No limitations /x/With limitations*

b.Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise covered under the plan.

/x/Provided: / /No limitations /x/With limitations*

c.Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub.45-4).

/x/ Provided: / /No limitations /x/With limitations*

3. Other laboratory and X-ray services.

/x/ Provided: / / No limitations /x/With limitations*

4.a.Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/x/Provided: / /No limitations /x/With limitations*

b.Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

/x/ Provided

c.Family planning services and supplies for individuals of childbearing age.

/x/Provided: / /No limitations /x/With limitations*

*Description provided on attachment.

State/Territory: MONTANA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(s): All Medically Needy

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5. a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___No limitations X With limitations:

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Medically Needy

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/ / Provided: / / No limitations / / With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Medically Needy

8. Private duty nursing services.

/X/ Provided: / / No limitations /X/ With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Medically Needy

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

b. Screening services.

/X/ Provided: / / No limitations /X/ With limitations*

c. Preventive services.

/X/ Provided: / / No limitations /X/ With limitations*

d. Rehabilitative services.

/X/ Provided: / / No limitations /X/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

b. Skilled nursing facility services.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Intermediate care facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

/X/ Provided: /_/ No limitations /X/ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/X/ Provided: /_/ No limitations /X/ With limitations*

17. Nurse-midwife services.

/X/ Provided: /_/ No limitations /X/ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All Medically Needy

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: ___ With limitations*

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Provided: + ___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided: + ___ Additional coverage ++ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: Montana

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/ With limitations*

c. Care and services provided in Christian Science sanitoria.

/_/ Provided: /_/ No limitations /_/ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/X/ Provided: /_/ No limitations /X/ With limitations*

e. Emergency hospital services.

/X/ Provided: /_/ No limitations /X/ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/X/ Provided: /_/ No limitations /X/ With limitations*

State/Territory: Montana

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided: ___ State Approved (Not Physician) Service Plan Allowed

___ Services Outside the Home Also Allowed

X Limitations Described on Attachment

___ Not provided.